COMMONWEALTH OF KENTUCKY
Cabinet for Health and Family Services
Department for Community Based Services

DPP-277
(R 10-05)

FAMILY CARE HOME SEMI-ANNUAL ASSESSMENT

A. IDENTIFYING DATA

Facility Name ________________ Number of Beds _____ Telephone________________
Address ________________________ Operator ____________________________
________________________________ Relief Person ____________________________

B. HOME ASSESSMENT INFORMATION (Circle appropriate response)

1. Does documentation reflect that medicines are being given as ordered? Yes No
2. Do menus reflect meals are well balanced? Yes No
3. Have you observed a meal? Yes No
4. Have there been changes in the number of people (residents and family members) residing in the home? Yes No If yes, explain______________________________
____
5. Any changes in the operator's physical, emotional or social status that might affect the care? Yes No ____
____
____
6. Any changes from the usual in physical environmental/housekeeping.? Yes No
If yes describe ____
____
7. Activities available to in the home to residents Yes No
8. Activities available outside the home to residents Yes No
List: ____
____
____
9. Since last assessment:
Any DSS- 284? Yes No
Any Protective Service Investigations Yes No
10. Residents moved since last assessment Yes No
If yes, give name and reason for move _______________________________
____
____
____
____
11. Deaths of residents since last assessment? Yes No
____
____
____
____

COMMONWEALTH OF KENTUCKY
Cabinet for Health and Family Services
Department for Community Based Services

DPP-277
(R 10-05)

C(1). RESIDENT ASSESSMENT (Circle appropriate responses)

NAME ______________________ **DOB/AGE** ______________

1. Is resident satisfied with placement? Yes No
   If no, what are the resident's concerns? ______________
2. Describe resident's emotional/mental status. ______________
3. Noticeable change in resident weight? Yes No
   If yes, explain ______________
4. Problems with grooming/hygiene? Yes No
   If yes, describe ______________
5. Is the resident
   Ambulatory? Yes No Mobile Nonambulatory? Yes No
   Needing Assistance? Yes No Bedfast Waiver Resident Yes No
6. Did the resident have physician contact, hospitalization, home health services since the last assessment? Yes No If yes, explain ______________
   ____
7. Medication changes since the last assessment? Yes No
   If yes, List: ______________
   ____
8. Is the resident restrained? Yes No
   If yes, explain ______________
9. Activity participation (List) ______________
   If none, explain ______________
   COMMENTS AND RECOMMENDATIONS: ______________
   ____

C(2).). RESIDENT ASSESSMENT (Circle appropriate responses)

NAME ______________________ **DOB/AGE** ______________

1. Is resident satisfied with placement? Yes No
   If no, what are the resident's concerns? ______________
2. Describe resident's emotional/mental status. ______________
3. Noticeable change in resident weight? Yes No
   If yes, explain ______________
4. Problems with grooming/hygiene? Yes No
   If yes, describe ______________
5. Is the resident
   Ambulatory? Yes No Mobile Nonambulatory? Yes No
   Needing Assistance? Yes No Bedfast Waiver Resident? Yes No
6. Did the resident have physician contact, hospitalization, home health services since the last assessment? Yes No If yes, explain ______________
   ____
7. Medication changes since the last assessment? Yes No

If yes, List: ____________________

____

8. Is the resident restrained? Yes No
   If yes, explain ____________________
9. Activity participation (List) ____________________
   If none, explain ____________________
   COMMENTS AND RECOMMENDATIONS: ____________________

____

C(3).). RESIDENT ASSESSMENT (Circle appropriate responses)

NAME ____________________ **DOB/AGE** ____________________

1. Is resident satisfied with placement? Yes No
   If no, what are the resident's concerns? ____________________
2. Describe resident's emotional/mental status. ____________________
3. Noticeable change in resident weight? Yes No
   If yes, explain ____________________
4. Problems with grooming/hygiene? Yes No
   If yes, describe ____________________
5. Is the resident
   Ambulatory? Yes No Mobile Nonambulatory? Yes No
   Needing Assistance? Yes No Bedfast Waiver Resident Yes No
6. Did the resident have physician contact, hospitalization, home health services since the last assessment? Yes No If yes, explain ____________________

____

7. Medication changes since the last assessment? Yes No
   If yes, List: ____________________

____

8. Is the resident restrained? Yes No
   If yes, explain ____________________
9. Activity participation (List) ____________________
   If none, explain ____________________
   COMMENTS AND RECOMMENDATIONS: ____________________

____

D. NEXT REVIEW DATE ____________________

E. WORKER'S SIGNATURE____________________ **DATE** ____________________